

**South Carolina Department of Disabilities  
And Special Needs**

**SERVICE COORDINATION MANUAL**

**Effective October 2007**

**Revised Effective April 22, 2009**

**Revised Effective January 1, 2010**

**Revised Effective November 2, 2010**

**Revised Effective July 1, 2011**

**SC Department of Disabilities and Special Needs**

## **Service Coordination Manual**

### **Scope and Intended Use:**

This manual is intended for use by Service Coordinators, Early Interventionists and administrative staff of all service coordination providers who contract with the South Carolina Department of Disabilities and Special Needs (DDSN) or Department of Health and Human Services (DHHS) to set forth the minimum requirements for Service Coordination.

### **Prepared By:**

The DDSN Office of Service Coordination, with input and information from people eligible for DDSN services, DDSN staff, Service Coordinators employed by DSN Boards and qualified providers and staff who provide other services from around the state.

### **Technical Assistance:**

Requests for technical assistance regarding Service Coordination Services should be directed to the appropriate DDSN District Office.

### **Additional Copies:**

Copies of this manual can be obtained from the DDSN Internet Web Site (<http://www.ddsn.sc.gov/about/directives-standards/Pages/CurrentDDSNStandards.aspx>) and/or by request from the DDSN Office of Service Coordination (803) 898-9715.

## TABLE OF CONTENTS

### Chapter 1: Introduction to Service Coordination and Person-Centered Practices

- I. What is DDSN Service Coordination?
- II. The Role of the Service Coordinator
- III. Key Skills for Service Coordination
- IV. Person-centered Approach and Planning

### Chapter 2: Standards

- I. Staff
- II. Duties, Responsibilities, and Service Content (Core Job Functions)
- III. Record Keeping and Documentation Requirements
- IV. Service Reporting
- V. Case Management Overlap and Hierarchy

## **CHAPTER 1**

### **INTRODUCTION TO SERVICE COORDINATION**

#### **I. WHAT IS DDSN SERVICE COORDINATION (also called Targeted Case Management)?**

The mission of DDSN is to assist people with intellectual disabilities or related disabilities and their families through choice in meeting needs, pursuing possibilities and achieving life goals and minimize the occurrence and reduce the severity of disabilities through prevention.

Consistent with DDSN's mission, the intent of DDSN Service Coordination is to assist people with an Intellectual Disability or a Related Disability, Autism, Traumatic Brain Injury, Spinal Cord Injury, and Similar Disability to access a full array of effective and cost efficient services and supports that are needed in order to avoid costly residential placement thereby making it possible for people to reside in their own homes and communities.

It is expected that DDSN service coordination services be provided in a manner that promotes:

- dignity and respect
- health, safety and well-being
- individual and family participation, choice control and responsibility
- relationships with family and friends and community connections
- personal growth and accomplishments

It is also expected that service coordination services reflect the principles of DDSN and therefore services should:

- be person centered
- be responsive, efficient, and accountable
- be strengths-based, results oriented
- maximize potential
- be based on best and promising practices

#### **II. THE ROLE OF THE SERVICE COORDINATOR**

The Service Coordinator is responsible for coordinating services to assure that people have access to a full array of needed community services including appropriate medical, social, educational or other needed services. The Service Coordinator is responsible for identifying the person's needs and resources, coordinating services to meet those needs and monitoring the provision of those needed services. More specifically, the Service Coordinator's job is composed of the following core functions:

##### **A. ASSESSMENT**

Informal needs assessment should occur as the Service Coordinator assists the person with the Intake process to determine eligibility for DDSN services and, generally, is ongoing throughout

the year. A more structured and comprehensive annual assessment and periodic reassessment of an individual is necessary to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include the following:

- Taking individual history
- Identifying the needs of the consumer and completing related documentation
- Gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the consumer

Needs assessment activities may also include reviewing information for or preparing a Level of Care re-evaluation to determine if a person continues to meet the ICF/ID Level of Care or Nursing Facility Level of Care.

Early Interventionist's complete a Family Assessment on an annual basis and a Curriculum Based Assessment every six months

## **B. CARE PLANNING**

Development (and periodic revision) of a specific care plan based on the information collected through assessment that includes the following:

- Specifies the goals and actions to address the medical, social, educational, and other services needed by the consumer;
- Includes activities such as ensuring the active participation of the consumer and working with that person (or that person's authorized health care decision maker) and others to develop such goals;
- Identifies a course of action to respond to the assessed needs of the consumer.

## **C. REFERRAL AND LINKAGE**

Referral and related activities (such as scheduling appointments for the consumer) to help the consumer obtain needed services, including activities that help link the individual with medical, social and education providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan. In the course of time during which a plan is implemented, a Service Coordinator may have to perform activities with a greater intensity and sense of urgency due to crisis circumstances affecting the person/family. The Service Coordinator may also need to advocate on behalf of the person in order to access services and supports or to protect the rights of the person or the family.

## **D. MONITORING or FOLLOW-UP**

Monitoring or follow-up activities include activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Monitoring and follow-up may be with the individual, family members, service

providers, or other entities or individuals. These activities may be conducted frequently as necessary (but at least every six (6) months as a part of Plan Review), to help determine whether the following conditions are met:

- Services are being furnished in accordance with the individual's care plan
- Services in the care plan are adequate to meet the needs of the individual
- There are changes in the needs or status of the eligible individual. If there are changes in the needs or status of the individual, monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with provider.

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

DDSN Service Coordination monitoring or follow-up to determine plan effectiveness may occur in a variety of ways or during a variety of activities to include:

- face-to-face contacts with the person receiving services
- home visits
- evaluation of services as they are being provided
- telephone calls, e-mails, mail, and/or fax correspondence(s) with the person, legal guardian, family, providers of services and supports received and appropriate others
- bi-monthly contacts
- six (6) month plan reviews
- monitoring newly implemented HCB Waiver services in accordance with the requirements in each specific Waiver manual
- completing monthly contacts and quarterly plan reviews for Pervasive Developmental Disorder (PDD) Waiver participants

### **III. KEY SKILLS FOR SERVICE COORDINATION**

Service Coordinators must possess many skills and abilities in order to provide quality services and to effectively perform the core functions of the job. The key skills for Service Coordination include those interpersonal skills that are needed to establish relationships with others including:

The ability to actively listen: to actively seek information from someone; to hear what and how something is being said; to communicate with and learn from another or from group reviews, written feedback, personal outcome interviews, etc.; to respect people served by allowing them to decide when and where communication takes place.

The ability to respond: to take information received about a person and assist in finding resources/services/supports to respond to needs; to respond to immediate requests (i.e. respond in a respectful and timely manner upon verbal requests, to respond to telephone calls immediately, respond in providing information to others, making timely referrals, etc.).

The ability to respect the person's perspective and experience: to be empathetic; to seek to understand the person before making recommendations for services; to give the person the same dignity, rights, and honor as other members of the community; assist people in exercising their rights that will facilitate personal goals.

The ability to resolve conflicts: be an effective mediator.

The ability to provide relevant information: to provide information that is concrete and specific enough to enable people to make informed decisions; facilitate visits, observations and experiences for people so informed choices can be made; having knowledge of local, state, federal, and community resources to be able to offer an array of choices.

The ability to promote natural support relationships: to assist in promoting or developing relationships that enable and encourage people to identify their goals and improve their lives; assist in establishing a support network that goes beyond typical/paid services/supports.

The ability to manage competing priorities: to be able to manage work where there are unpredictable situations such as when needs develop, crisis situations occur, etc.

The ability to think critically: to be able to think about situations and respond to them or provide solution, to make professional judgments based on an array of information.

#### **IV. PERSON-CENTERED APPROACH AND PLANNING**

A person-centered approach is a strategy that, when employed, allows the Service Coordinator to learn about a person with an intellectual disability or related disability in order to support that person to create a lifestyle that allows him/her to fully participate as an active citizen who contributes to the life of the community. A person-centered approach is more than a meeting; it is a system of beliefs and values employed when people work together (person being served, legal guardian, friends, staff, etc.) to assist with the creation of a lifestyle based on the person's needs, interests and preferences. In other words, the focus of person-centered approaches should be to assist a person receiving services to have a meaningful life as they define it, which requires more than merely accessing services. All planning that occurs on behalf of people served should be person-centered. The group of people assembled to work with the person/legal guardian is commonly known as the 'circle of support,' which includes people that the person receiving services/legal guardian desires to be involved in the process. A circle of support might include the person served, friends, neighbors, family, Service Coordinator, service providers, other professionals who work with the person being served and any other natural supports that are meaningful in their life.

Today many people with intellectual disabilities or a related disability are seeking more control over their lives. Their focus is on choice and self-determination in all areas of life, but especially in those that affect friends, neighbors, home, work, finance and leisure. Ideally, people receiving services should be directing their lives. People with intellectual disabilities or a related disability have the right to determine their personal goals, the responsibility to share those goals with

professionals when assistance to attain them is desired, and the right to decide which services and supports they want to meet their needs. These services and supports include natural and community resources, as well as traditional agency services.

Some people with intellectual disabilities or a related disability are capable of identifying and obtaining supports and services on their own. Others have family members, friends, and other natural supports to help them. However, many people with intellectual disabilities or a related disability and their families prefer professional assistance in developing a plan, which is part of the type of assistance that Service Coordinators can provide. Service Coordinators help people receiving services explore what they want and need in life. They work in partnership with the person/legal guardian to develop, implement, monitor and maintain the person's plan. Service Coordinators assist people to attain the highest quality of life as defined by them. Two activities of Service Coordination that are especially critical deal with protecting and upholding a person's human and civil rights and assuring their health and safety needs.

While the Service Coordinator is responsible for the development and implementation of the annual plan, it is the person receiving services and/or legal guardian who guide the Service Coordinator in identifying and fulfilling needs. In order for this to happen, the Service Coordinator must develop and maintain a relationship and partnership with the person receiving services and/or legal guardian, come to know the person's personal goals and needs, and be able to advocate for the person. It is this personal relationship with the person receiving services and/or legal guardian, and the positioning of the person in the driver's seat that is at the heart of person-centered planning.

#### IMPORTANT NOTE

Because there will be an indefinite time during which a complete case record will be comprised of both paper and electronic documents, these standards and guidance have been modified in order to reflect the use of both.

## STANDARDS

### I. Staff

Standards	Guidance
<p>A. Service Coordination services shall be rendered by qualified staff.</p> <p><b><u>1. Service Coordination Supervisors (SCSs)</u></b> must hold a Master's degree in Social Work or a related field from an accredited university or college and have at least one (1) year of experience in programs for people with disabilities or have at least one (1) year of experience in a case management program and demonstrate knowledge of disabilities</p> <p style="text-align: center;">Or</p> <p>Hold a Bachelor's degree in Social Work or a related field from an accredited university/college and have at least three (3) years of experience working with people with disabilities or have at least three (3) years experience in a case management program and demonstrate knowledge of disabilities.</p> <p>Early Intervention Supervisors-must hold a Bachelor's degree in a related field from an accredited university/college and have either: one (1) year of experience in the field of early childhood education, OR one (1) year of experience working with infants and toddlers, OR one (1) year of experience with children age birth to five (5) years with disabilities AND one (1) year of case management experience.</p> <p><b><u>2. Service Coordinators(SCs)</u></b> must hold at least a Bachelor's degree in Social Work or a <u>related</u> field from an</p>	<p>Requests for exception to the required Service Coordination Supervisor qualifications can be made to the Office of Quality Management, DDSN.</p> <p>Activities of Service Coordination Supervisors, Service Coordinators and Service Coordination Assistants who do not meet qualifications are <u>NOT reportable</u>. There are no exceptions.</p> <p>A Service Coordination Supervisor may perform any and all of the required functions of a Service Coordinator <u>ONLY</u> if they meet the requirements of a Service Coordinator.</p> <p>A person with a family relationship to a consumer may not provide Service Coordination to that consumer.</p> <p>If a potential employee does not meet the requirements in I. "Staff" A.# 2 of this document, a request for exception to the requirement for a Master's Degree can be requested from the DDSN Quality Management Division Director. The Certification and Licensing Standards, Request for Exception (Form 929) must be completed and submitted to the Quality Management Division Director (one time approval).</p> <p>Early Intervention Exception-Anyone hired prior to September 1, 2006, who does not meet the educational requirements is required to have an approved exception. The Certification and Licensing Standards, Request for Exception (Form 929) must be completed and submitted to the Quality Management Division Director annually. No exceptions to the educational requirements are allowed after September 1, 2006. All staff must meet the requirements spelled out above.</p> <p>Activities of Service Coordination Assistants whose documentation is not co-signed by a Service Coordinator/Service Coordination Supervisor are <u>NOT reportable</u>. The activities of a Service Coordination Assistant are</p>

Standards	Guidance
<p>accredited college or university</p> <p>Or</p> <p>Hold at least a Bachelor's degree in an <u>unrelated</u> field from an accredited college/university AND have at least one (1) year of experience in programs for people with disabilities or have at least one (1) in a case management program and demonstrate knowledge of disabilities</p> <p>Or</p> <p>Hold a Master's Degree and have at least one (1) year of experience in health and human services if providing Service Coordination to people with a Traumatic Brain Injury (TBI) or a Spinal Cord Injury (SCI).</p> <p><b><u>3. Service Coordination Assistants (SCAs)</u></b> must hold a high school diploma/GED (or higher) and must have the skills and competencies sufficient to perform the tasks to which they may be assigned or the capacity to acquire those skills and competencies.</p>	<p>primarily administrative or clerical in nature. Duties performed by an Assistant in support of Service Coordination may include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>• General clerical duties such as filing, copying, faxing, typing, etc.</li> <li>• Identification of resources to meet individuals' needs.</li> <li>• Responding to requests for information and referral.</li> <li>• Accompanying Service Coordinators to interagency staffing, intra-agency staffing, IEP meetings and other meetings.</li> <li>• Gathering records and information and submitting eligibility requests and requests for Level of Care evaluations including tracking service delivery due dates.</li> <li>• Gathering records and information to begin completion of the Service Coordination Annual Assessment.</li> <li>• Identification and recruitment of caregivers.</li> <li>• Reviewing and reconciling waiver budgets and expenditures.</li> <li>• Monitoring consumer satisfaction</li> </ul> <p><b>Service Coordination assistants may not:</b></p> <ul style="list-style-type: none"> <li>• Complete CAP Assessments</li> <li>• Develop or complete CAP Service Plans</li> <li>• Complete an Add Need</li> <li>• Complete CAP Need/Service/Intervention Changes</li> <li>• Complete CAP monitoring of the plan</li> <li>• Complete electronic service notes</li> <li>• Attend interagency staffing and meetings (though a Service Coordination Assistant may accompany)</li> <li>• Attending court ordered hearings or other legal proceedings (though a Service Coordination Assistant may accompany)</li> <li>• Develop waiver budgets and revisions</li> <li>• Complete re-evaluations of ICF/ID Level of Care</li> <li>• Have a caseload of Level I DDSN eligible people. (Assistants may have a caseload of non-eligible people during Intake)</li> </ul>
B. Each Service Coordination Assistant,	

Standards	Guidance
<p>Service Coordinator, or Service Coordination Supervisor must be an employee of DDSN, a DSN Board, or a DDSN qualified Service Coordination provider.</p>	
<p>C. Each Service Coordination provider shall maintain:</p> <ol style="list-style-type: none"> <li>1. a current list of staff members</li> <li>2. a signature sheet for service coordination assistants, Service Coordinators and Service Coordination Supervisors which includes all signature and initial variations used by those staff</li> <li>3. a credentials folder for each staff member which includes: <ol style="list-style-type: none"> <li>a. Resume/Equivalent Application</li> <li>b. Certified copies of transcripts/diplomas from an accredited university or college</li> <li>c. Training records</li> <li>d. Job description</li> <li>e. Documentation of required experience</li> <li>f. Annual performance evaluations and initial background checks according to DDSN Directive 406-04-DD: Criminal Record Checks and Reference Checks of Direct Caregivers</li> </ol> </li> </ol>	<p>Service Coordinators are considered to be “direct caregivers” in accordance with S.C. Code Ann. §44-7-2910 because a Service Coordinator’s duties include the “possibility of patient or client contact.”</p>
<p>D. Service Coordination staff must be trained.</p> <ol style="list-style-type: none"> <li>1. Service Coordination staff (hired after November 2, 2010) must be provided training at a minimum in the following topic areas as a DHHS-approved curriculum and</li> </ol>	<p>Records must reflect that information presented in training was comprehended by the Service Coordinator.</p> <p>Providers, at their discretion, may require Service Coordination staff to have additional training beyond the minimum established by these standards in order to ensure knowledge and skills competency. Training is not limited to a classroom setting and may</p>

Standards	Guidance
<p>must demonstrate competency in these topics:</p> <ol style="list-style-type: none"> <li>a. DDSN Service Coordination Standards including, but not limited to Assessment, Care Planning, Referral and Linkage, Monitoring or Follow Up and reportable and non-reportable activities including service note documentation.</li> <li>b. Basic service coordination skills</li> <li>c. DDSN policies and procedures applicable to Service Coordination</li> <li>d. Rights of consumers</li> <li>e. Local, state, and national resources that comprise the system of care for DDSN's target populations.</li> <li>f. Access to and use of CDSS/STS</li> <li>g. Nature of Intellectual Disabilities, Autism, traumatic brain injury, spinal cord injury and similar disability (as appropriate)</li> <li>h. Abuse and Neglect</li> <li>i. Confidentiality</li> </ol> <ol style="list-style-type: none"> <li>2. Prior to performing a specific job duty, newly employed Service Coordination Assistants will have training specifically related to each of their job duties and responsibilities.</li> <li>3. After the first year of employment,</li> </ol>	<p>include the following activities if they are related to the professional practice of Service Coordination and services to persons with intellectual disabilities or a related disability:</p> <ul style="list-style-type: none"> <li>• Shadowing an experienced Service Coordinator or other professional staff</li> <li>• One on one instruction (not routine supervision) by a Supervisor or other designated staff</li> <li>• Site visits to disability programs and services of other community service providers for the purpose of understanding the disability community and its service provider network</li> </ul> <p>“Topics related to the provision of Service Coordination services” (Item D.#3. in left column) includes content which supports or enhances core job functions and the duties and responsibilities of Service Coordination. Some of these topics may be found in DDSN Directive 567-01-DD: Employee Orientation, Pre-Service and Annual Training Requirements. Except for the required annual topics of Item D. #3, specific training topics after the first year of employment are determined at the discretion of and according to the perceived needs of the provider. These topics may include but are not limited to:</p> <ul style="list-style-type: none"> <li>• DSN policies and procedures</li> <li>• Effective Communication</li> <li>• Gathering Information for planning</li> <li>• Community Resources and Agency Interface</li> <li>• Time and Stress Management</li> <li>• Person-centered philosophy and concepts</li> <li>• Analyzing, Organizing, and Managing Information including both paper and electronic records</li> <li>• Sensitivity to individual/family uniqueness</li> <li>• Advocacy, Negotiation, and Problem-Solving</li> <li>• Pertinent Legislation</li> <li>• Self-Advocacy and Self-Determination</li> <li>• Assistive Technology and AT resources</li> <li>• Working collaboratively with others</li> <li>• Documentation and Preparing Written Documents</li> <li>• Crisis Intervention Management</li> <li>• Condition/Diagnosis- Specific Information</li> </ul>

Standards	Guidance
<p>all Service Coordination staff must receive a minimum of 12 hours of training annually on topics related to the provision of Service Coordination services and <b><u>must include training on Abuse and Neglect and Confidentiality.</u></b></p> <p>Early Interventionists are required to receive an additional 10 hours of job related training annually. This requirement is in addition to the online training requirements as spelled out in the Comprehensive System of Personnel Development Standards included in the Part C BabyNet Manual.</p>	<ul style="list-style-type: none"> <li>• Teamwork and Leadership</li> <li>• Measures of Effectiveness of Case Management</li> <li>• Risk Management</li> <li>• Healthcare Guidelines and Screening</li> <li>• Emergency Planning for People With Special Needs</li> </ul>
<p>E. Service Coordination providers must be accessible to people served and must have a system in place which allows people served to receive assistance with any crisis situation 24 hours a day, 7 days a week.</p>	<p>ACCESSIBILITY: If necessary, a back-up on-call system may be implemented which will allow immediate accessibility for people receiving services. People receiving services and providers should be encouraged to call 911 in the event of a medical or police emergency; however, Service Coordination providers must still be accessible to provide assistance as needed. It is acceptable to have a general on-call number (beyond working hours) provided there is a response to crisis calls within two (2) hours.</p>

## II. Duties, Responsibilities, and Service Content (Core Job Functions)

Standards	Guidance
<p><b>A. INTAKE</b></p> <ol style="list-style-type: none"> <li>1. Service Coordinator or agency designee must call the applicant/legal guardian within seven (7) business days of the provider receiving the referral in the unassigned bucket from a screener.</li> <li>2. Appropriate intake forms must be provided to, explained to, and signed by applicants for DDSN eligibility or their legal guardians.</li> <li>3. Social history information must be secured and documented during intake.</li> <li>4. When an eligibility packet is completed, it must be sent to the Consumer Assessment Team (CAT) within five (5) business days of completion.</li> <li>5. If eligibility is not determined within 90 calendar days of the case open date, documentation must be available to show that the applicant was notified of the reason for delay and informed of their movement to Level II Service Coordination.</li> <li>6. If eligibility has not been determined within 180 calendar days from case open date, there is documentation in the primary case record to show that options were discussed with the applicant.</li> <li>7. Documentation is in the file</li> </ol>	<p>Intake is the combination of activities that lead to a determination of eligibility or ineligibility for DDSN services. Intake begins after a person is screened in and makes their first choice of a Service Coordinator/Early Intervention provider. The date of this choice establishes the <u>Case Open Date</u> on CDSS. The screener then makes the transfer to the chosen provider accepting the referral.</p> <p>If the screening disposition to the chosen provider indicates that the applicant has also requested waiver services, a waiver slot allocation request will be processed according to guidance of the applicable waiver manual.</p> <p>Intake ends with notification to the applicant/legal guardian of the eligibility decision, including any appeals that might be initiated.</p> <p>If a person's record has been closed after previously being served by DDSN, all Intake standards and guidance apply if they again seek DDSN services.</p> <p>Because contact must be made with the person/legal guardian within seven (7) business days of referral to the Service Coordination provider of choice, a referral should not be left indefinitely in the "unassigned bucket" in CDSS.</p> <p>Service Coordination Assistants may assume all intake duties provided the Service Coordinator or Service Coordinator Supervisor signs off on manual service notes or completes electronic service notes reflecting intake activities.</p> <p>The completion of the DDSN Needs Assessment in the Consumer Assessment and Planning module of CDSS does not begin until eligibility has been determined and the person has been moved back to Level I by District staff as a result of the Service Coordination levels assessment. If the person is not moved to Level I, no comprehensive needs assessment or plan is required. However, the comprehensive needs assessment in CAP must be completed prior to completion of the CAP plan.</p>

Standards	Guidance
<p>showing the applicant was notified of the DDSN eligibility determination.</p>	<p>During <b>Intake</b> as records are gathered for eligibility determination, it is a good time to begin an <u>informal</u> assessment of need and even to <u>think</u> ahead to the plan.</p> <p>REQUIRED INTAKE FORMS: The required intake forms include the following:</p> <ul style="list-style-type: none"> <li>• <b>DDSN Service Agreement and Permission to Evaluate:</b> A valid, signed and dated DDSN Service Agreement form must be in the primary case record <u>before</u> a Service Coordinator may begin to provide services.</li> <li>• <b>Release/Request for Information:</b> These forms are required <u>before</u> a Service Coordinator can contact providers of services or request information regarding the applicant.</li> <li>• <b>HIPAA Acknowledgment form</b></li> <li>• <b>Genetic Services Consent Form</b> (for ID/RD eligibility applicants only)</li> </ul> <p>The <b>Acknowledgement of Service Coordinator/Early Intervention Choice form</b> does not have to be signed by the applicant/legal guardian after their selection of a Serve Coordinator/Early Intervention provider to begin the intake process for eligibility. However, the <u>screener</u> will offer the person a choice of Service Coordinator/Early Intervention providers to begin intake for eligibility.</p> <p>Required intake forms must be signed by the eligibility applicant if 18 years of age or older and not adjudicated incompetent. If the applicant is under age 18 or adjudicated incompetent, the legal guardian must sign the intake forms. (Note: Official documentation of legal guardianship should be obtained and kept in the primary case record at all times)</p> <p>New intake forms must be obtained when the person reaches age 18 and is not adjudicated incompetent, if there is a name change of the person and/or legal guardian, or if there is a change in legal guardianship.</p> <p>New required Intake forms (excepting Request for Information form unless needed) must be in the primary case record of Level I Service Coordination recipients <b>within 90 calendar days</b> of the person's 18<sup>th</sup> birthday or</p>

Standards	Guidance
	<p>other event that requires a new form.</p> <p>New intake forms need to be obtained when a person returns to DDSN for services after their file was previously closed.</p> <p>If a person turns 18 or there is a change in guardianship while they are on <u>Inactive status</u> or receiving <u>Level II</u> Service Coordination, it will not be necessary to update the required forms until the person moves to Level I Service Coordination status. (When a person is moved to Level I, required forms must be updated within 90 calendar days of the date of movement)</p> <p>Release/Request of Information forms will only need to be signed as needed or requested.</p> <p>If a person is <u>unable to consent</u> according to DDSN Directive 535-07 DD: Obtaining Consent for Minors or Adults, then consent must be obtained consistent with this directive.</p> <p>If the person is able to consent but is unable to write their signature, their “Mark” is acceptable. This “Mark” must be witnessed by signature on the same form. Circumstances of the Mark and witness should be included in the service notes.</p> <p>Social history is to be documented on the Consumer Information Summary (CIS) that is provided to the Consumer Assessment Team (CAT) as part of the intake packet. Early Interventionists also capture Social History information through the DDSN CIS form.</p> <p>The CIS will be retained in the case record.</p> <p>Required paperwork to submit to CAT:</p> <ul style="list-style-type: none"> <li>• Consumer Information Summary (CIS)</li> <li>• Functional Assessment and Background Information (FABI) – for HASCI Division referrals only</li> <li>• Medical reports/records</li> <li>• Psychological examination reports</li> <li>• Other information supporting diagnosis and any functional limitations</li> </ul>

Standards	Guidance
	<p data-bbox="740 195 1469 556">TIMEFRAMES: DDSN eligibility should be pursued as quickly as possible without regard to the preceding Best Practice (not mandatory) time frames. For those people in critical or urgent referral status, the Service Coordinator/Service Coordinator Assistant must document accelerated and continuous attempts to obtain an eligibility decision in less than the maximum timeframe. If an eligibility decision has not been made within 90 calendar days of the case open date, the Service Coordinator/Service Coordinator Assistant will:</p> <ul data-bbox="740 598 1469 1039" style="list-style-type: none"> <li>• discuss with the applicant/legal guardian the reasons for delay in eligibility</li> <li>• inform the applicant/legal guardian of movement to Level II Service Coordination and any implications to that change</li> <li>• document the discussion in the service notes</li> <li>• inform the Service Coordination Supervisor of reasons for the delay</li> <li>• continue to work with the applicant/legal guardian to complete the eligibility packet for an additional 90 calendar days unless otherwise indicated by the applicant/legal guardian</li> </ul> <p data-bbox="740 1081 1469 1186">No Service Coordination activity is billable to Medicaid after 90 calendar days in Intake though service notes should continue to document core function activity.</p> <p data-bbox="740 1228 1469 1480">If eligibility is delayed due to the Service Coordinator/Service Coordinator Assistant being unable to locate or contact the applicant/legal guardian, the Service Coordinator/Service Coordinator Assistant will meet with the Service Coordination Supervisor to discuss the case and determine if intake should be extended or the case closed.</p> <p data-bbox="740 1522 1469 1875">If eligibility is not determined within 180 calendar days of the Case Open Date, the Service Coordinator/Service Coordinator Assistant will discuss the reason for delay with the applicant/legal guardian, choices of further extension or case closure, and the option of re-applying if services are needed in the future. Any discussions and contacts with the applicant/legal guardian during the intake process, along with justification for any extensions, must be documented in service notes. If an extension is chosen, the Service Coordinator will notify</p>

Standards	Guidance
	<p>the Service Coordination Supervisor, who will notify the Executive Director.</p> <p>If a request for a DDSN Home Community Based (HCB) Waiver has been made for someone later found not eligible for services, the appropriate DDSN Waiver Coordinator should be involved regarding notification of Appeals.</p> <p>The Intake worker will notify the applicant of the eligibility determination and will document the notification in service notes. If an applicant is eligible for services through DDSN and is returned to Level I by the District Office, the Service Coordinator should continue/begin the assessment and planning process.</p> <p>If an applicant is not found eligible for services, <u>written notice</u> of the eligibility decision will be provided to the applicant within <u>five (5) business days</u> of the provider's receipt of the eligibility decision. The notice will be in writing and will include information on the right to appeal eligibility denial and the procedures for appeal. Upon request of the applicant, the Service Coordinator must read or explain the eligibility decision and appeal procedures to the applicant if eligibility is denied. The Service Coordinator will also provide information and referral to appropriate community resources or other agencies based on the person's disability and needs.</p>
<p><b>B. ASSESSMENT (CORE FUNCTION)</b></p> <ol style="list-style-type: none"> <li>1. A comprehensive assessment of the person's needs must: <ol style="list-style-type: none"> <li>a. be completed prior to the initiation of the Plan</li> <li>b. be completed at least annually</li> <li>c. be completed using the Consumer Assessment and Planning (CAP) module of the Consumer Data Support System (CDSS)</li> <li>d. be completed when there is a crisis (crisis intervention) or when interventions are needed to address specific and</li> </ol> </li> </ol>	<p><b>NEEDS ASSESSMENT:</b></p> <p>Needs assessment may include a wide range of activities to obtain and to review information to determine a person's personal goals and needs in order to develop an accurate and effective Support Plan. Needs assessment is based upon an evaluation of the person's environmental, economic, psycho-social, medical, and any other factors that impact the person. Personal observations and interviews are important elements of needs assessment, especially during home visits, other face-to-face contacts, and during contacts with providers of services/supports or with any other people involved in the person's life.</p> <p>The expectation is that if the person has had a Life Plan completed, the Life Plan should be considered part of the overall assessment of needs for a person and noted as one</p>

Standards	Guidance
<p>identifiable problems (regular intervention)</p> <p>Early Interventionist's complete a Family Assessment on an annual basis and a Curriculum Based Assessment every six (6) months. Both assessments are completed prior to plan development.</p> <p>2. A Level I/Level II assessment must be completed NO MORE THAN ten (10) business days prior to:</p> <ul style="list-style-type: none"> <li>a. transfer from Early Intervention to Service Coordination</li> <li>b. movement to Level II by a provider</li> <li>c. a request to move from Level II to Level I by a provider.</li> </ul>	<p>of the documents/records that were reviewed. Personal goals may or may not be included in the service coordination plan but should <u>always</u> be considered for inclusion.</p> <p>The comprehensive needs assessment within CAP must be completed prior to completion of the plan. This same assessment may need to be completed more than once a year <u>particularly if the person/family is in crisis or if any major changes occur in the life of the person</u> or at any time the Service Coordinator considers it necessary for appropriate planning.</p> <p>Ongoing informal assessment will occur throughout the year during regular contacts to assure that a person's goals and needs are still consistent and are accurately reflected on the Plan.</p> <p>IDENTIFYING/UPDATING NEEDS: Current needs may be identified during the year which may require previously identified needs to be discontinued or revised. All newly identified needs, as well as previous goals/needs that are revised or discontinued must be noted on the Plan by using the CAP module of CDSS and documented in the service notes.</p> <p>Updates are not to be made to the Service Coordinator Annual Assessment that is completed in the CAP module.</p> <p>REGULAR INTERVENTION: Time spent with the person/legal guardian to deal with specific and identifiable problems which require the Service Coordinator's guidance. The problem does not place the individual in jeopardy and the timeframe is not immediate.</p> <p>CRISIS INTERVENTION: Immediate response to specific needs which, if not met, would put the person in jeopardy. Crisis Intervention involves activities to respond to any emergency, life-threatening circumstance or health and safety issue arising in the life of the person which requires immediate assessment and resolution.</p>

Standards	Guidance
	<p>Steps in addressing problem/crisis situations:</p> <ul style="list-style-type: none"> <li>• <b>Assessment of problem/crisis:</b> gather information in the event of a crisis situation with assistance from the person affected, family members, other current providers or others involved in order to identify the immediate problem and any potential health and safety hazards which may affect the person.</li> <li>• <b>Addressing problem:</b> identify and implement steps to address the crisis situation in the best and safest way possible</li> <li>• <b>Follow-up/monitoring:</b> follow up to assure that all necessary actions/services were provided, and to monitor if the crisis is resolved or if any additional action or services may be required</li> </ul> <p><b>REPORTING OF ABUSE/CRITICAL INCIDENTS</b></p> <p>In the event of a finding of or an allegation of abuse or the occurrence of a critical incident as defined by DDSN policy, the Service Coordinator and/or the provider involved is responsible to complete a Report of Abuse or Critical Incident (per DDSN Directive 534-02-DD: Procedures for Preventing and Reporting Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or a Contracted Provider Agency). Service Coordinators will monitor any circumstances that are the subject of a report of abuse or critical incident involving the person with the person to ensure that they are safe and well. The service notes will show that the Service Coordinator monitored and/or took appropriate actions to implement recommendations in final written reports of abuse and critical incidents.</p> <p><b>SERVICE COORDINATION LEVEL</b></p> <p>The Service Coordinator must assess the person's need for ongoing Service Coordination. Once the person is assigned to a Service Coordination Level I, the level should be <u>reviewed</u> annually during the assessment/planning process. A person's Service Coordination level should also be <u>reviewed</u> when needs significantly change or when the person experiences a major life change. The Level I/Level II Service Coordination Assessment is not required to be completed</p>

Standards	Guidance
	<p>at each subsequent annual review but the status must be <u>reviewed</u> and documentation should be included on the Plan. (Please refer to DDSN Directive 700-04-DD: Levels of Service Coordination)</p> <p>Documentation of Level I Service Coordination status should be indicated on the first page of the Support Plan.</p> <p>Movement of someone from Level II to Level I Service Coordination can occur only with approval from DDSN. A District Office or the HASCI Division will issue the approval according to procedures defined by those offices.</p>
<p>C. CARE PLANNING (CORE FUNCTION)</p> <p>1. A Plan must:</p> <ol style="list-style-type: none"> <li>be completed within 45 calendar days of movement from Level II to Level I for children not DDSN-eligible and who have been awaiting enrollment in the PDD waiver</li> <li>be completed within 45 calendar days from date of transfer for those moving from Level II to Level I Service Coordination, or moving from Early Intervention services to Service Coordination</li> <li>be completed prior to the delivery of DDSN operated Home and Community Based Waiver service.</li> <li>be completed annually (must be completed every 365 calendar days) on the Consumer Assessment and Planning (CAP) module of CDSS. Note: Early Interventionist do not complete plans on CAP.</li> </ol>	<p>Care planning will identify and document the personal needs of the person receiving services and the services and supports necessary to address them. Personal goals identified through a Life Plan or by other means may or may not be included within the Service Coordination Plan. However, the Service Coordinator is expected to consider personal goals and preferences though they may or may not be appropriate for or possible to include in the completed plan.</p> <p>Care Planning, Referral and Linkage and other core functions are not required for those on Level II Service Coordination or for those whose case is closed.</p> <p>The plan must be completed before any Waiver services can be authorized.</p> <p>For those receiving Level I Service Coordination, a plan must be completed <u>within</u> 365 calendar days of the last plan date on CAP module of CDSS. For example, if a person's plan date is July 31, 2010, the next plan <u>must</u> be completed on or prior to the 365<sup>th</sup> day from July 31, 2010, (i.e. on or prior to July 30, 2011).</p> <p>REGARDING PLAN TIMEFRAMES:</p> <p><b><u>The date that a plan is completed on CAP is the date of the Service Coordinator's electronic signature AND the effective date of the plan.</u></b></p> <p>It is not necessary for Service Coordinators to sign all Plans received as a result of <u>transfers</u> from one provider</p>

Standards	Guidance
<p>e. when <u>not</u> completed on CAP, be signed (or initialed) by the Service Coordinator, titled and dated on the top of every page</p> <p>f. when <u>not</u> completed on CAP, be signed by the person, his/her parent, guardian, or legal representative if available. If unavailable for signature, the reason must be documented.</p> <p>g. when not completed on CAP, be placed in the person's file within 10 business days of the Plan completion date.</p> <p>h. reflect if consideration is being given to the need for contact in excess of the minimum requirements.</p> <p>i. include information about the person's plan for responding to emergencies.</p> <p>Early Interventionists do not capture emergency plans but do complete an annual safety checklist with the family</p> <p>j. address identified health and safety needs for persons placed in DDSN residential settings or in contractual residential settings.</p> <p>k. be current at all times</p> <p>2. A copy of the completed plan must be provided to the person, parent, legal guardian or legal representative and documented in the service notes.</p> <p>3. Documentation must reflect that a</p>	<p>to another or one caseworker to another.</p> <p>Plans completed on CAP are NOT required to be printed and placed in the file. If, for some reason, a plan is printed from CAP to be placed in the person's file/record, the Service Coordinator must attempt to obtain the person's, his/her parent's/guardian's/legal representative's signature on the plan. If the person/parent/guardian/legal representative is unavailable, documentation of why the signature could not be obtained must be entered in the file/record. It is not required to have the plan signed when printing the plan from CAP for a copy to be mailed to the person/legal guardian/legal representative/parent.</p> <p>WHEN A SERVICE COORDINATOR IS NOTIFIED THAT A RESIDENT IS BEING DISCHARGED FROM AN ICF/ID to a less restrictive community setting, the Service Coordinator should begin assessment and planning prior to the discharge. The Service Coordination Plan must be in place prior to authorizing Waiver services. Before the discharge, the plan cannot be completed on CAP (can only be completed on paper). After the discharge, the plan should be keyed into the CAP module (the same plan that was completed on paper can be reviewed, keyed and entered into CAP with a new effective date, thus, creating a new plan review/date – the paper plan must be retained in the file to show a plan was developed prior to authorizing Waiver services).</p> <p>Each person/legal guardian must be offered the opportunity to meet with the Service Coordinator face-to-face; this offering must be documented. If a plan meeting is desired, the person/legal guardian may request that others of his/her choosing be invited to this meeting. Meetings should be held at times and locations that are reasonable (within the county for which the person resides and/or the county where the chosen Service Coordination provider provides services) and convenient for all parties.</p> <p>The Service Coordinator must document that the person, parent, legal guardian and/or legal representative <u>was involved in the planning process</u>. Documentation may be:</p>

Standards	Guidance
<p>choice of Service Coordination provider is offered annually during planning to those who are DDSN eligible and Level I.</p> <p>4. Transfer to a new service coordination provider must occur on CDSS and the file is mailed/postmarked or otherwise delivered within ten (10) business days of the request. A “signed receipt” should be obtained to document receiving ownership of the transferred file by the receiving provider.</p> <p>Early Intervention Manual requires a case transfer take place in two (2) working days.</p>	<ul style="list-style-type: none"> <li>• in the form of a plan meeting sign-in sheet</li> <li>• a service note describing his/her involvement in the planning process, to include Assessment</li> </ul> <p>Payment for any services that are being provided for a person without a current/valid plan may be subject to sanctions/recoupment when identified through quality assurance reviews, Medicaid audits, or other means.</p> <p><b>CHANGES TO THE PLAN</b></p> <p>The Service Coordinator will ensure that adding new needs and needs/service/intervention changes to the Plan are completed in the CAP module. Updates of social and demographic information must be made in the CDSS and the file within five (5) business days of notification. Updates to the CAP Needs Assessment and any changes to other sections of the Support Plan should be referenced in service notes. The needs assessment cannot be updated electronically in CAP after a plan is completed.</p> <p>Additional contact beyond the minimum bi-monthly contact (monthly for Early Intervention) must be considered at least annually and, if additional contact is needed, the need must be included on the Support Plan. Additional contact may mean an increase in the frequency of the contact (i. e., contact more frequently than bi-monthly, monthly for Early Intervention contacts, for some or all services/supports), an increase in the intensity of contact (i. e., face-to-face contact at regular intervals rather than face to face contact every six (6) months) or a combination of increased frequency and intensity.</p> <p>When considering the need for additional contact, consider if circumstances such as, but not limited to, the following exist:</p> <ul style="list-style-type: none"> <li>• The person does not effectively communicate problems or concerns to others. (Does the person make needs known verbally or through sign language? Can the person indicate such things as how he/she got a bruise or how his/her money was spent?)</li> </ul>

Standards	Guidance
	<ul style="list-style-type: none"> <li>• The person is physically dependent on others for basic care. (Does he/she have any capacity to physically protect him/herself?)</li> <li>• The person engages in behaviors that are mentally and physically challenging for caregivers. (e.g., hitting, spitting, kicking, name calling, taunting, cursing, extreme uncooperativeness, etc.)</li> <li>• The person does not have regular contact with family or friends who are not paid agency employees. (If family and friends are available, do they assist the person in decision-making or advocate on his/her behalf and in his/her best interest?)</li> </ul> <p>The presence of circumstances such as these above may indicate an increased vulnerability and, therefore, indicate a need for increased contact.</p> <p>Emergency Plans (for what to do in event of an emergency) must include, but not be limited to, the following components:</p> <p><u>For people residing in DDSN sponsored residential settings,</u></p> <ul style="list-style-type: none"> <li>• a statement regarding the location of the detailed emergency disaster plan</li> </ul> <p><u>For people in all other settings (including non-DDSN sponsored residential settings),</u></p> <ul style="list-style-type: none"> <li>• plans in the event of an emergency/natural disaster or loss of primary caregiver</li> <li>• identification of transportation services/supports to be used and/or how the person will be transported</li> <li>• where the person will evacuate to if an evacuation is required</li> </ul> <p>Updates of emergency planning information during the course of a plan year will be noted in the service notes and updated during annual plan development on the plan.</p>

Standards	Guidance
	<p>Generally, no services should be authorized or provided <u>in the absence of a current plan. Exceptions include the provision of Service Coordination within time frames for plan development and state funded services may possibly be provided for:</u></p> <ul style="list-style-type: none"> <li>• <u>people who are moved back to Level I after eligibility determination</u></li> <li>• <u>eligible children coming from Early Intervention to Level I Service Coordination</u></li> <li>• <u>people receiving Level II Service Coordination</u></li> </ul> <p>If a person has a <b>Life Plan</b>, the Service Coordinator must review and consider the recommendations. Although personal goals may or may not be addressed as a formal need on the Service Coordination Plan, the Service Coordinator will at least advocate for all service providers to address and incorporate personal goals into all service plans. Life Planning is not necessarily linked to the Service Coordination Plan and may be provided at any point during the Plan year. Life Planning is a separate service used to assist in identifying personal goals and priorities.</p> <p>During annual planning, Service Coordinators must inform a person/legal guardian of all available Service Coordination or Early Intervention providers and offer them a choice of providers. If the person does not choose to change providers at the annual review, it will not be necessary to obtain a new “Acknowledgement of Service Coordinator/Early Interventionist Choice” form. The current Service Coordinator will document that a choice was offered.</p> <p>Service Coordinators should be responsive to a request for a change in Service Coordination provider with documentation that choice was offered.</p>
<p>D. REFERRAL AND LINKAGE (CORE FUNCTION)</p> <ol style="list-style-type: none"> <li>1. The plan must be implemented.</li> <li>2. Service Coordinators will respond</li> </ol>	<p>A Plan is implemented when a Service Coordinator:</p> <ul style="list-style-type: none"> <li>• helps the person to obtain needed services</li> <li>• acts to develop new resources if none are currently available</li> </ul>

Standards	Guidance
<p>to areas of identified need and must begin implementation of activities to address needs within ten (10) business days from the date of identification unless otherwise specified in the annual plan.</p> <p>3. When a referral is made by the Service Coordinator to a new service <u>provider</u> (for both new and ongoing <u>services</u>), the Service Coordinator will follow up with the consumer and the service provider within 30 calendar days after the first service delivery date to determine whether the service and provider appear appropriate to address the need.</p> <p>4. The Service Coordinator must ensure that the person's freedom of choice of providers is maintained including choice of Service Coordination provider. These choices must be documented.</p> <p>5. Documentation must reflect a choice of Service Coordination provider was offered:</p> <ol style="list-style-type: none"> <li>annually during planning to those who are DDSN eligible and Level I.</li> <li>when the person requests a change of provider.</li> </ol> <p>6. At initial planning and annual planning thereafter, all people receiving Level I Service Coordination will be provided an estimate of the cost of services they receive.</p> <p>7. People to receive Level II Service Coordination will be informed at</p>	<ul style="list-style-type: none"> <li>acts to maintain and coordinate services and supports currently received</li> <li>acts to link the person with providers of services or programs that are capable of meeting identified needs</li> </ul> <p>As the person's situation changes, the needs, services and supports identified in the Plan for the person served may also change.</p> <p><b>IDENTIFYING/DEVELOPING RESOURCES AND REFERRALS</b></p> <p>Once the Plan is completed and approved, the Service Coordinator will assist the person receiving services/legal guardian in identifying appropriate providers for needed services and arranging for services.</p> <p>The Service Coordinator will advocate for the development of new resources if needed services are not available, for access to existing services when the consumers' rights are denied, and for the provision of quality, timely and effective services that meet the needs of the consumer. This advocate's role may be particularly necessary regarding access to healthcare and a clean safe living environment. As needs are identified during planning or throughout the year, Service Coordinators will respond to and provide assistance in meeting the needs. "Respond to and provide assistance" is not considered to be the actual act of completing <i>all</i> activities in addressing needs, but rather is defined as making contacts with the person and/or other appropriate individuals to coordinate activities in meeting needs.</p> <p><b>CONSULTATION/COLLABORATION</b> is the sharing of information between and joint problem solving with service providers and other professionals to gain a better understanding of a person's current situation and to determine the best course of action to address identified personal needs. Consultation/Collaboration is an important, if not essential, element in all of the core functions of Service Coordination.</p> <p>Coordination by the Service Coordinator may include, but is not limited to:</p>

Standards	Guidance
<p>the time of notification of movement to Level II that an estimate of the cost of services they receive, <u>if any</u>, is available upon request.</p> <p>8. All people receiving Level I Service Coordination will be provided information on what is and how to report incidents of abuse, neglect and exploitation annually.</p>	<ul style="list-style-type: none"> <li>• Coordinating access to all necessary services available to people with intellectual disabilities or a related disability (including services available to Medicaid recipients and available within the community)</li> <li>• Assists people in obtaining <u>all</u> needed services identified in the Plan, including all services covered by Medicaid</li> <li>• Coordinates services from multiple agencies that are required to meet individual's needs. May attend public school meetings, community support meetings, and meetings with any organization or person on behalf of the person receiving services (if invited and notified of those meetings)</li> <li>• Coordinates access to primary care physicians, local DSS programs, county health departments, and other local service providers</li> <li>• Coordinates services within local DSN programs or contracted private providers and effects transfers to appropriate services within DSN programs or contracted private providers which are indicated by the person's Plan</li> <li>• Arranges needed family support services/funds if indicated as a need in the Plan</li> <li>• Arranges/coordinates for a person's access to a primary health care physician and access to other health care providers based on a person's healthcare needs</li> <li>• Authorizes services under a DDSN Home and Community based Waiver when appropriate</li> <li>• Coordinates transportation to medical appointments through the county DSS and other local providers</li> </ul> <p><b>CHOICE OF PROVIDERS</b></p> <p>The person receiving services or legal guardian must be given a choice of all qualified providers of services and</p>

Standards	Guidance
	<p>supports. The initial choice of provider is offered by the screening agency prior to intake beginning.</p> <p>Choice should be offered at a minimum of annually during plan development, any time the person receiving services or legal guardian requests a change in services or providers, or when a new need is identified. It must be documented in service notes that a choice of providers was offered and what the person receiving services/legal guardian's choice was. If there is only one potential provider for a particular area, the person receiving services/legal guardian must be informed and the Service Coordinator must document this discussion in a service note.</p> <p>If the person does not choose to change providers at the annual review, it will not be necessary to obtain a new "Acknowledgement of Service Coordinator/Early Interventionist Choice" form. The current Service Coordinator will document that a choice was offered.</p> <p>Service Coordinators should be responsive to preferences of the person/legal guardian and to a request for a change in <u>any</u> service provider. Documentation must reflect that a choice was offered.</p> <p><b>AUTHORIZING SERVICES</b></p> <p>Once appropriate providers have been identified, and the Plan and funding have been approved, the Service Coordinator will send the appropriate authorization or referral form to the provider notifying them they are authorized to provide a particular service. For MR/RD, PDD, CS and HASCI Waiver services, the appropriate Waiver authorization form should be used and a copy forwarded to the provider <u>prior</u> to the start date of services. (Refer to MR/RD, PDD, CS or HASCI Waiver guidelines for appropriate forms). For people receiving State-funded Day Services, the Service Coordinator will use the "Referral for State Funded Day Services" located in R2D2, Business Tools with Service Coordination forms.</p> <p>People receiving Level I Service Coordination services will be provided an estimated, not actual, cost of services. The estimate of cost is based on the current</p>

Standards	Guidance
	<p>array of services/supports they are receiving. Factors such as actual attendance in residential and day programs, fluctuations in use of services (such as PCA and nursing), and delays in direct billings to Medicaid make providing actual costs on a routine basis difficult. The DDSN standardized Microsoft Excel spreadsheet to compute an estimated cost of services is available for use or a provider may use a spreadsheet approved by DDSN Finance. The estimate of the cost of services will generally be prepared by the Service Coordinator with any additional cost data provided by the Finance Director of the provider. The provider can opt to have other staff prepare the cost estimate to give to the Service Coordinator. (Refer to Memo dated 8/29/06 from the DDSN Director of Cost Analysis for specific instruction or contact the Office of the Director of Cost Analysis.)</p> <p>Information regarding abuse, neglect, and exploitation will be provided by Service Coordination providers annually for all people receiving Level I Service Coordination explaining who is a vulnerable adult, what is abuse, neglect, and exploitation and providers phone numbers of where to report suspected abuse cases if they occur in a community setting or in a facility.</p>
<p><b>E. MONITORING OR FOLLOW UP (CORE FUNCTION)</b></p> <ol style="list-style-type: none"> <li>1. At least every six (6) months, the Plan must be monitored to ensure: <ol style="list-style-type: none"> <li>a. services are received and are effective</li> <li>b. person/legal guardian is satisfied</li> <li>c. the Plan continues to be appropriate to address needs</li> <li>d. progress or lack of progress toward meeting needs that is on the plan</li> </ol> <p>Note: <u>Plan reviews</u> will be completed <u>quarterly</u> with PDD</p> </li> </ol>	<p><b>MONITORING OR FOLLOW-UP</b></p> <p>This core function includes activities and contacts that are necessary to ensure the plan is implemented effectively and is adequately addressing the needs of the person.</p> <p>Monitoring or follow up may occur by many different means including but not limited to, home visits, face-to-face contacts, mail correspondences, email or telephone calls with the person receiving services, legal guardian, family, natural supports and providers of services and supports received.</p> <p><b>PLAN REVIEW</b></p> <p>In order to ensure the plan continues to meet the person's current personal goals and needs, it must be continually monitored/reviewed throughout the year and must be formally monitored/reviewed every six (6) months. The completion of the annual plan is considered a six (6)</p>

Standards	Guidance
<p>Waiver recipients/legal guardian/responsible party. Monitoring/contacts will be completed monthly for PDD Waiver recipients (Refer to PDD Waiver Manual for specific requirements).</p> <ol style="list-style-type: none"> <li>2. The person's access to a primary health care provider and other health care providers is monitored as needed based on the person's health care needs</li> <li>3. The frequency and intensity of monitoring or follow up is determined based on the skills, abilities and resources available to the person</li> <li>4. Plan Monitoring every six (6) months must be done with the involvement of the person being served and/or their legal guardian.</li> </ol>	<p>month Plan Monitoring; the completion of other Plan Monitoring will be expected by the last day of the sixth month following the annual plan date. Plan Monitoring will be completed using the CAP module of CDSS. Monitoring, other than the Plan Monitoring/review every six (6) months, may be documented in the service notes as long as the same content is considered.</p> <p>Plan Monitoring/review every six (6) months will consist of monitoring/reviewing all current needs to determine if interventions identified to meet goals/needs have been implemented, if interventions were useful and effective, and if the person receiving services/legal guardian is satisfied with the interventions/services and the provider of services. Effectiveness or progress towards meeting a need on the plan should be noted in the "Comments" section of the CAP monitoring form or in a corresponding service note. As Plan Monitoring/review every six (6) months occurs, expressed personal goals and preferences of the person/legal guardian will be considered. If any changes/revisions need to occur as a result, the plan must be updated (using the CAP module of CDSS) to include an explanation of the change/update.</p> <p><b>MONITORING COMPONENTS</b></p> <p>Monitoring of services/Plan Monitoring/review every six (6) months should include the following components:</p> <p><i>(It is not required that each component be included for every monitoring opportunity, although all components should be included with each Plan Monitoring every six (6) months)</i></p> <ul style="list-style-type: none"> <li>• Services and supports are implemented as agreed upon in the Support Plan and continue to be appropriate and effective to meet the needs of the consumer as evidenced by observable or documented progress</li> <li>• Services and supports continue to address any changing circumstances of the person, particularly those which support health and safety or they are modified accordingly</li> <li>• Services and supports are of a quality to ensure</li> </ul>

Standards	Guidance
	<p>that the person receiving the service or legal guardian continues to be satisfied with services and providers</p> <p>People receiving Level II Service Coordination do not have a current plan and do not require an intensive level of Service Coordination involvement. Therefore, they will not require any Service Coordination monitoring.</p>

### III. Record Keeping and Documentation

Standards	Guidance
<p>A. A primary case record will be maintained for each person receiving services.</p> <p>B. The primary case record must follow a File Index as determined by the provider agency.</p> <p>C. As appropriate records will include, but are not limited to, the following:</p> <ol style="list-style-type: none"> <li>1. Assessment Information (including the DDSN Service Coordination Annual Assessment and any Level I/II Assessment)</li> <li>2. Current Plan and previous year's plan in paper or electronic format as applicable (if receiving Level I Service Coordination). The paper file will identify records that are maintained electronically</li> <li>3. Level II Agreement (if receiving Level II Service Coordination and the assignment was not a result of 90 calendar days in intake or eligibility determination)</li> <li>4. Initial Social History Assessment (CIS) and updates (if applicable)</li> <li>5. Medical information as applicable and when available</li> <li>6. Psychological Assessment, if applicable</li> <li>7. IEPs, IFSPs, FSPs, if applicable by age</li> <li>8. Eligibility Letter (after 1988)</li> </ol>	<p><b><u>SEE IMPORTANT NOTE REGARDING RECORDS ON PAGE 8, GUIDANCE</u></b></p> <p>Case records (paper files <u>and</u> electronic records) maintained by the Service Coordinator are considered to be the person's primary case record with DDSN. Primary case records should be logically and consistently organized such that the identification of needs, referrals, follow-up, plan development and monitoring can be easily and clearly reviewed, copied, and audited. Service Coordination providers will have the flexibility to use the filing system of their choice (i.e., six-section divided files, 3-ring binders, etc.). Service notes should provide a clear/concise description of the circumstances being recorded. The contents should be current, complete, timely, and meet documentation requirements. Documentation and record organization should also permit someone unfamiliar with the person receiving services to quickly assume knowledge sufficient to provide Service Coordination, or to review the records to assure compliance with contracts, policies, standards and procedures.</p> <p>Purged record contents should also be maintained according to the provider agency's File Index and in close proximity to the primary case record. HASCI Waiver recipient's files must follow the HASCI Waiver index (refer to the HASCI Waiver Manual). Closed records and backup records will also be retained according to the provider's primary case record index. Closed case records must be retained for a period of no less than six (6) years after the end of the annual contract period. If any litigation, claims or other actions involving the records are initiated prior to the expiration of the six (6) year period, the records must be retained until completion of the actions and resolution of all issues which arise from it, or until the end of the required period whichever is later. (For more detailed information regarding record retention, please refer to DDSN Directive 368-01-DD: Individual Service Delivery Records Management.</p>

Standards	Guidance
<p>9. Valid Service Agreement</p> <p>10. Contact/Service Notes in paper or electronic format as applicable. The paper file will indicate records that are maintained electronically HIPAA Acknowledgement</p> <p>11. Acknowledgement of Service Coordinator/Early Interventionist Choice (when required)</p> <p>12. Correspondence, including emails, and any other documentation intended to support Medicaid reimbursement for Service Coordination</p> <p>13. Legal records determining competency or determining a change in legal guardianship or documenting a legal name change, if applicable</p> <p>14. Information from other service agencies providing services to the person</p> <p>15. Other documents which from time to time may be deemed essential by DDSN or the state Medicaid agency</p>	
<p>D. For participants who are enrolled in a DDSN operated Home Community Based Waiver; the person's record contains the required forms as outlined by the Waiver manual.</p>	<p>Waiver Forms including but not limited to:</p> <ul style="list-style-type: none"> <li>a. Waiver enrollment and disenrollment forms</li> <li>b. Waiver budget information</li> <li>c. <b>ALL</b> Level of Care forms</li> <li>d. Freedom of Choice form</li> <li>e. Waiver Acknowledgement of Choice form</li> <li>f. Waiver Acknowledgement of Rights and Responsibilities form</li> <li>g. Waiver authorization and termination forms</li> <li>h. Other Waiver forms as required in the PDD, MR/RD, CS, and HASCI Waiver manuals</li> </ul>

Standards	Guidance
E. The primary case record including the electronic assessment, planning, monitoring and service note system will be kept secure according to DDSN and HIPAA security, confidentiality and privacy policies.	<p>Refer to DDSN Directives:</p> <p>167-06-DD: Confidentiality of Personal Information  368-01-DD: Individual Service Delivery Records Management  367-12-DD: Computer Data Security</p>
F. Service notes must document all Service Coordination activity on behalf of the specific person represented by the primary case record and, upon review, must justify the need for Service Coordination.	Multiple actions which support the same activity and which occurred on the same day may be incorporated into a single service note provided all necessary information is included and is clear to any other readers or reviewers.
<p>G. I. Service notes will include the following if a reportable core function activity is being documented as a result of a contact:</p> <ol style="list-style-type: none"> <li>1. Name and title of person being contacted</li> <li>2. Type of contact</li> <li>3. Location of contact</li> <li>4. Purpose of contact</li> <li>5. Intervention or services provided</li> <li>6. The outcome</li> <li>7. Needed follow-up</li> </ol> <p>II. The Service Coordinator must make contact with or on behalf of the person, at least every other month (i.e., bi-monthly).</p> <p>Early Interventionists make monthly contacts.</p> <p>Monthly contacts/monitoring is required for PDD Waiver recipients.</p> <p>The Service Coordinator must have a face</p>	<p>A contact is defined as any of the following:</p> <ul style="list-style-type: none"> <li>• A face to face visit for the purpose of performing a core function</li> <li>• A telephone call, letter or email for the purpose of performing a core job function when a face to face contact is not required or is not practical due to circumstances</li> </ul> <p>Activities by the Service Coordinator such as written correspondence, completed reports and completion/updates to the Support Plan must be documented in service notes to include identification and location in the record of any referenced documents. It is <b>not</b> necessary to document receipt of program reports, correspondence, etc., <b>unless</b> the Service Coordinator is reviewing these for the purpose of monitoring. The presence of the documents in the record itself will serve as documentation of their receipt. (Note: Service notes stating that “Service Coordinator received and reviewed progress notes” will <b>NOT</b> be acceptable for documenting a core function. If progress notes are reviewed, for example, for the purpose of monitoring a service, documentation should include details regarding progress toward goals, effectiveness of service, etc. and not just reference the completed monitoring form)</p>

Standards	Guidance
<p>-to -face visit with the person every six (6) months.</p>	
<p>H. All service notes must:</p> <ol style="list-style-type: none"> <li>1. be entered on CDSS beginning July 1, 2010</li> <li>2. be completed within five (5) business days of the activity/event being documented</li> <li>3. be <u>completed</u> on CDSS so that activities may be reported to DDSN for billing</li> <li>4. be labeled as a “Late Entry” when the Service Coordinator is not able to complete a note within five (5) business days from the time that the activity occurred</li> <li>5. Be completed by someone credentialed to be a Service Coordinator</li> </ol> <p>Early Intervention documentation is not completed using CDSS.</p>	<p>The Best Practice (not mandatory) is to complete service notes on the day that a service or activity is rendered. Service notes on CDSS are the electronic documentation of core functions and other activities performed by the Service Coordinator. The service note module of CDSS is in accordance with the Uniform Electronic Transactions Act (S.C. Code Ann. §26-6-10 et seq.)</p> <p>When a service note for a core function activity is completed on CDSS, it is automatically transmitted to DDSN for <u>possible</u> billing. If a note is “Saved” (not completed), the note is still in progress and will not be reported to DDSN for possible billing.</p> <p>Having “saved” service notes (i.e., notes not completed) will prevent the transfer of the person to another provider until the note is either completed or terminated.</p> <p>Service notes completed on CDSS do not have to be printed and placed in the primary case record.</p> <p>Any manually signed service notes written by a Service Coordination Assistant prior to July1, 2010 must be co-signed by a credentialed Service Coordinator.</p> <p><b>TRANSFER OF FILES:</b></p> <p>When a transfer must be made to a different Service Coordinator/Early Intervention provider, the following steps should be followed to prevent any disruption in services:</p> <p>The <u>sending</u> Service Coordination provider should:</p>

Standards	Guidance
	<ul style="list-style-type: none"> <li>• Get the Acknowledgement of Service Coordinator/Early Interventionist Choice form signed. If the chosen new provider is the DSN Board of the county of residence, the DSN Board must accept the transfer. If the chosen new provider is an approved private provider or DSN Board outside the home county, the new provider must accept the transfer before it is made. The sending provider should always alert the chosen provider by email or phone or fax before transferring the record on CDSS. If a person independently contacts/chooses another provider or if any circumstances prohibit the sending provider from doing so, the receiving provider/Service Coordinator will get the Acknowledgement of Service Coordinator/Early Interventionist Choice form signed</li> <li>• Contact receiving Service Coordination provider to discuss the logistics of transferring, discuss services and providers, and set a date for mailing the case record and transfer on CDSS</li> </ul> <p>All items below the asterisk line must be completed within ten (10) business days of the transfer on CDSS.</p> <p>*****</p> <ul style="list-style-type: none"> <li>• Reconcile waiver budget to close out services; complete any outstanding service notes</li> <li>• Update/change CDSS as needed</li> <li>• Review case record with Service Coordination Supervisor</li> <li>• Terminate services, if necessary, and notify all service providers. (Note: Service termination may not be necessary when the person is not moving out of the immediate area or is choosing a different Service Coordination provider)</li> <li>• Copy the case record and maintain <u>a copy</u> of all records of service according to DDSN Directive 368-01-DD: Individual Service Delivery Records Management</li> <li>• Send <u>originals</u> of the paper case record to the</li> </ul>

Standards	Guidance
	<p>receiving Service Coordination provider.</p> <p>The <u>receiving</u> Service Coordination provider should:</p> <ul style="list-style-type: none"> <li>• Ensure that the home board provider on the CDSS (county to county transfers only) is correct</li> <li>• Notify DDSN Cost Analysis Division to set up a new Waiver budget (waiver recipients only)</li> <li>• Update budget and services on the CDSS (for Waiver recipients, complete new Waiver budget within 20 business days of transfer on CDSS)</li> <li>• Contact chosen providers and authorize services <u>if</u> necessary</li> <li>• Update existing plan or complete a new plan as necessary</li> <li>• Organize all case record information and insert into a file</li> </ul>
I. All manual service notes must be typed or handwritten in black or dark blue ink.	Electronic service notes can only be typed and printed in black (or can be printed in blue ink if printer prints in blue – no other ink color variations are permissible).
J. All service notes must be legible and kept in chronological order according to the date of entry.	Any notes done out of chronological order should be labeled as “Late Entry.” If a provider chooses to print electronic service notes for the primary case record and for non-electronic service notes, late entries must be filed according to the date they were <u>completed</u> , not on the date of the activity that is described in the notes.
K. All manual and electronic service notes must be dated and legibly signed with the Service Coordinator’s name or initials, professional title, and dated.	<p>Non-electronic service notes must be manually signed by a Service Coordinator.</p> <p>When a review of non-electronic service notes reveals that a service note was not signed when written, the note must be signed immediately by a credentialed Service Coordinator and that signature given the <u>current</u> date. A current service note must be written to explain the difference between the signature date and the date the note was actually written. If the activity described in the unsigned note was previously reported on the Service Provision Log (SPL), this is <b>NOT</b> considered a reporting</p>

Standards	Guidance
	<p>error that must be corrected.</p> <p>If initials are used with manually signed documents, these must be included on a signature sheet maintained at the Service Coordination provider's office.</p> <p>Service Coordination staff is given exclusively assigned pin numbers as electronic signatures to validate an electronic assessment, plan, monitoring, and service note as a genuine and true reflection of Service Coordination activity. Electronic signatures will be placed at appropriate locations on electronic documents and will be recognized by the phrase "Electronically signed by..." The date that the document was signed will also appear along with the title of <u>Service Coordinator</u>. Pin numbers may be obtained by contacting the Help Desk of DDSN's IT Department.</p>
<p>L. If a service <u>is</u> reported for billing during a given month, there <u>must</u> be a service note documenting the performance of a reportable activity during that month.</p>	<p>For non-electronic service notes when no documentation is present in the record during a month in which a service is reported on an SPL, this IS considered a reporting error that must be corrected.</p> <p>Completed electronic service notes and the reporting of those notes for billing purposes are automatically linked in the electronic service note system. There is no separate manual service reporting process for electronic service notes.</p>
<p>M. A list of any abbreviations or symbols used in the records must be maintained.</p>	<p>This list must be clear as to the meaning of each abbreviation or symbol, and only abbreviations and symbols on this approved list may be used.</p>
<p>N. Any person(s) referenced in service notes or any supporting correspondences must be identified in each entry.</p>	<p>Identify person(s) in service notes by their full name and title or relationship to the person. References in service notes must be done at least one time for each entry/service note.</p>
<p>O. Errors in service notes must be corrected appropriately.</p>	<p>When an error is made in a <u>non-electronic service note</u>, the Service Coordinator should clearly draw <u>one line</u> through the error, write "error" to the side in parentheses, enter the correction, and add the Service Coordinator's signature or initials and date. If additional explanation about the correction is appropriate, this must also be included in a service note. The information contained in the error must remain legible, and no correction fluid or</p>

Standards	Guidance
	<p>erasable ink may be used.</p> <p>When an error is made in an <u>electronic service note</u>, the Service Coordinator will follow error correction procedures identified in the system as “Revision to the Completed Service Note”. The corrected service note and the previous incorrect note for a specific person may be seen together in “Print/View History” when the original service note date is clicked on CDSS.</p>
<p>P. Service notes must be individualized to the specific person represented by the primary case record.</p>	<p>A single <u>identical</u> service note cannot be used to document activity about two (2) or more consumers.</p>

## IV. Service Reporting

Standards	Guidance
<p>Electronic service notes intended to document core function activities should be sufficient in content to support billing to Medicaid. <b>(Reference III Recordkeeping and Documentation, Item F.)</b></p>	<p>Reportable Service Coordination activities must represent at least one of the four core job functions which were previously defined in Chapter 1 of this manual. These core job functions are the primary activities/duties Service Coordinators perform. Activities which fall within the definition of one of these categories of services are the <u>only</u> activities Service Coordinators may report. <b>No activities on behalf of those on Level II Service Coordination should be reported on the SPL. However, all core function and non-reportable activities for persons on Level II should be documented in service notes.</b></p> <p>Service Coordinators may back-report for any activities for which a 'Late Entry' service note is completed for a period of up to 12 months after the date the activity actually occurred.</p> <p><b>INITIAL REPORTING</b></p> <p>No Service Coordination activity is reportable until a case is opened on CDSS and until a Service Agreement form is signed regardless of the number of service notes or the type of activity that they describe. Electronic service notes, including core function and non-reportable activities may be entered as soon as the person is assigned to a Service Coordinator as DDSN will determine whether Medicaid may be billed.</p> <p><b>SUPPORT PLAN</b></p> <p>Service Coordination activity may be reported <u>only</u> when a current Support Plan is in place or when a plan is in process according to established timeframes. If a plan is not in place or not in process within established time frames, the activity must be documented as non-reportable.</p> <p><b>PERSON/APPLICANT NOT LOCATED</b></p> <p>If a DDSN applicant or DDSN eligible person is missing and his/her whereabouts cannot be determined within 30 calendar days, Service Coordination activity must not be reported until that person is located. Reporting must be</p>

Standards	Guidance
	<p>discontinued after 30 calendar days from the date the Service Coordinator is made aware of the person missing, <u>not</u> the actual date the person went missing. After 30 calendar days, all Service Coordination activity is <u>not reportable</u> until such time as the person is located and documented by a service note. As mentioned previously, core function and non-reportable electronic service notes may be entered at any time.</p> <p><b>SERVICE PROVIDER REPORTS</b></p> <p>The reading or reviewing of reports from service providers in and of itself is <u>not</u> reportable on SPL and is not considered a core function for electronic notes. Service notes should document the reviewing of reports for the purpose of identifying needs or monitoring services or progress toward identified goals in order for this activity to represent a core function in electronic notes.</p> <p><b>RTF/IMD and ICF/ID Placement</b></p> <p>For people in Residential Treatment Facilities (RTF)/Institutions for Mental Disease (IMD) such as New Hope, Charter, Patrick B. Harris Psychiatric Hospital, and S.C. State Hospital, DHHS case management hierarchy must be followed. (Please refer to the complete copy of the DHHS case management hierarchy at the end of this document.) Service Coordination services are limited to:</p> <p>(a) assuring that a placement continues to be necessary and appropriate to meet the person's needs and  (b) planning for future placement. Reportable activities may include:</p> <ul style="list-style-type: none"> <li>• Assessment of treatment or placement needs on an ongoing basis to ensure that the person continues to require the RTF/IMD level of care</li> <li>• Participation in treatment planning meetings, IEP meetings or other agency (RTF/IMD) program or service planning meetings</li> <li>• Planning for future placement(s), assuring that a placement is appropriate to meet individual needs</li> </ul>

Standards	Guidance
	<p>and is the least restrictive placement possible</p> <ul style="list-style-type: none"> <li>• Contact or consultation with other agencies or providers to assure appropriateness of a placement</li> <li>• Crisis assessment and referral services when a placement disrupts</li> <li>• Case management services which are required to maintain a person in a temporary alternative placement</li> <li>• Activities to gather information for an ICF/ID Level of Care with the intention of obtaining ICF/ID placement or waiver services</li> <li>• Activities related to transition and discharge planning for someone within 180 calendar days of discharge from an ICF/ID or other institutional setting</li> </ul> <p>RESIDENTIAL and ALTERNATIVE PLACEMENTS:</p> <p>There are no Service Coordination reporting restrictions (as there are for RTF/IMD placements) for individuals in DDSN residential placements and DDSN funded alternative (out-of-home) placements such as supervised independent living, high and moderate management group homes, specialized treatment services for sexual offenders, therapeutic foster care providers, and intensive crisis care. The DHHS case management hierarchy at the end of this document must be followed.</p> <p>EXAMPLES OF <u>NON-REPORTABLE</u> ACTIVITIES</p> <p>A variety of ‘non-Service Coordination’ activities, which commonly occur in a normal work environment, may be required of a Service Coordinator or other provider agency staff, but are not reportable. These types of activities are very important in providing quality person-centered services for individuals and families, but do not fit into the definition of one of the four core job functions and therefore are not reportable.</p> <p>The following activities are <u>not</u> reportable on the SPL or electronically and are administrative in nature:</p>

Standards	Guidance
	<ul style="list-style-type: none"> <li>• Prior authorization for Medicaid services</li> <li>• Referral and monitoring of one's own activities</li> <li>• Completion of any requested information regarding consumers for the provider, public agencies or other private entities for administrative purposes</li> <li>• Participation in recreation or socialization activities with the consumer or his/her family</li> <li>• Activities performed for the person, such as shopping or errands</li> <li>• Contacts solely for the purpose of medication or appointment reminders</li> <li>• Activities on behalf of deceased individuals or their families</li> <li>• Verification of Medicaid numbers</li> <li>• Medicaid eligibility determinations and re-determinations (Activities on behalf of TEFRA Medicaid applicants seeking ICF/ID Level of Care are <u>not</u> reportable as this is part of a Medicaid eligibility process)</li> <li>• Transportation of individuals or family members for any purpose (Service Coordinators may perform reportable activities, such as monitoring, while transporting and these are reportable)</li> <li>• <u>Attempted</u> reportable activities which were never completed (The attempt should be documented in service notes)</li> <li>• Review of an individual's primary case record (such as might occur when the individual is new to a caseload)</li> <li>• Provision of information about an individual for administrative purposes (such as during a contractual compliance review). Activities rendered during court proceedings (South Carolina Family Court, General Sessions Court, or Federal Court) which are</li> </ul>

Standards	Guidance
	<p>convened to address criminal charges against the individual, custody or other judicial matters by the person or others</p> <ul style="list-style-type: none"> <li>• General activities with individuals in institutional settings (such as ICF/IDs, adult correctional facilities, juvenile reception and evaluation centers or correctional facilities). An exception is made when a person is within 180 calendar days of discharge from an ICF/ID or other institutional setting. Activities related to transition and discharge planning is billable if the person is Level I</li> <li>• The act of writing service notes</li> <li>• Completing statistical reports</li> <li>• Clerical activities such as typing, copying, faxing and filing</li> <li>• Composing form letters not personalized to the individual</li> <li>• Completing forms for DDSN Family Support funding. (However, discussion with the individual/legal guardian regarding the request and the gathering of information to support the request may be reportable)</li> <li>• Services to a hospice recipient <u>unless</u> a prior authorization number has been obtained from the hospice provider</li> <li>• Performing duties of a day or residential staff as a result of their unplanned absence</li> <li>• Fund-raising activities</li> <li>• General office management</li> <li>• Management of agency vehicles</li> <li>• Serving on DSN Board committees or inter-agency workgroups</li> <li>• Any activities on behalf of individuals receiving Level II Service Coordination</li> </ul>

## **V. Case Management Overlap**

<b>Standards</b>	<b>Guidance</b>
A. When more than one case management provider is providing services, services must be provided in accordance with The Medicaid Case Management Overlap and Hierarchy.	Refer to Case Management Hierarchy Guidelines at the end of this document.

# **MEDICAID CASE MANAGEMENT OVERLAP AND HIERARCHY**

These case management and hierarchy guidelines of the Department of Health and Human Services (DHHS) are intended to assist Service Coordinators in understanding their roles and their service reporting responsibilities when a DDSN consumer has multiple Medicaid-funded case managers.

## **CASE MANAGEMENT OVERLAP**

Some individuals who are dually diagnosed or have complex social and/or medical problems may require services from more than one case management provider to be successfully managed and/or integrated into the community. The needs and resources of each individual may change over time as well as the need for case management services from another provider. Case management providers must work closely and cooperatively if the recipient's needs are to be adequately met and duplication of services and Medicaid payments are to be avoided. A system must exist within each case management program to assure that service providers are communicating, coordinating care and services, and adequately meeting individual needs

## **CASE MANAGEMENT HIERARCHY GUIDELINES**

A Primary Targeted Case Manager as well as a secondary provider for each overlapping situation must be determined. The Primary Case Manager shall:

- a) ensure access to services,
- b) arrange needed care and services,
- c) monitor the case on an ongoing basis,
- d) provide crisis assessment and referral services,
- e) provide needed follow-up, and
- f) communicate (by telephone or face-to-face) regularly with other involved agencies/providers.

Concurrent Care shall be rendered to an individual to which another provider has been designated the Primary Case Manager. The Concurrent Care provider shall, in a timely manner, notify the Primary Case Manager about:

- a) changes in the individual/family's situation they have identified,
- b) needs, problems or progress,
- c) required referrals, and
- d) treatment/service planning meetings.

The Concurrent Care provider will render different, distinctive types of services from the Primary Case Manager. Billing is restricted to specific activities.

Concurrent service providers will render treatment related, case management-like services. Ancillary Services procedure codes have been set up for concurrent service providers.

If overlap occurs, these guidelines shall be followed:

**CCEDC/IFCCS:** Overlap between these two programs is not permissible, except when cases are transitioning between the two agencies

**DMH/IFCCS:** IFCCS primary case manager with DMH providing concurrent care

**DJJ/IFCCS:** IFCCS primary case manager with DJJ providing concurrent care

**CCEDC/Sickle Cell:** CCEDC primary case manager with Sickle Cell providing concurrent services.

**CCEDC/DDSN Service Coordination:** CCEDC primary case manager with DDSN providing concurrent care.

**CCEDC/DDSN Early Intervention (EI):** CCEDC primary case manager with EI providing concurrent care.

**CCEDC/DMH:** CCEDC primary case manager with DMH providing concurrent services.

**CCEDC/DAODAS:** CCEDC primary case manager with DAODAS providing concurrent services.

**CCEDC/CLTC:** CLTC primary case manager with CCEDC providing concurrent care.

**CCEDC/SCSDB – Commission For Blind:** CCEDC primary case manager with SCSDB – Commission for Blind providing concurrent care.

**CCEDC/DJJ:** CCEDC primary case manager with DJJ providing concurrent care.

**DDSN Service Coordination/DDSN Early Intervention:** Overlap is not permissible.

**DDSN/IFCCS:** IFCCS primary case manager with DDSN providing concurrent care.

**DDSN/DMH:** DDSN primary case manager with DMH providing concurrent services.

**DDSN/DAODAS:** DDSN primary case manager with DAODAS providing concurrent services.

**DDSN/Sickle Cell:** DDSN primary case manager with Sickle Cell providing concurrent services.

**DDSN/SCSDB – Commission For Blind:** SCSDB – Commission for Blind primary case manager with DDSN providing concurrent care.

**DDSN/CLTC:** CLTC primary case manager with DDSN providing concurrent care. DDSN primary case manager for children (0 to 18) receiving CLTC Personal Care Aide Only services.

**DDSN/ DSS Adult Services:** DDSN primary case manager with DSS providing concurrent care.

**DDSN/DJJ:** DDSN primary with DJJ providing concurrent care.

**DDSN Early Intervention/DMH:** DDSN primary case manager with DMH providing concurrent services.

**DDSN Early Intervention/DAODAS:** Overlap not anticipated.

**DDSN Early Intervention/Sickle Cell:** DDSN primary case manager with Sickle Cell providing concurrent services.

**DDSN Early Intervention/SCSDB – Commission For Blind:** SCSDB primary case manager with DDSN providing concurrent care. DDSN primary case manager with Commission for Blind providing concurrent care.

**DDSN Early Intervention/CLTC:** CLTC primary case manager with DDSN providing concurrent care.

**DDSN Early Intervention/DSS IFCCS:** DDSN primary case manager with DSS providing concurrent care.

**DMH/DJJ:** DMH primary case manager with DJJ providing concurrent care

**KEY:**

<b>CCEDC</b>	= Continuum of Care for Emotionally Disturbed Children
<b>CLTC</b>	= Community Long Term Care
<b>DAODAS</b>	= Department of Alcohol and Other Drug Abuse Services
<b>DDSN</b>	= Department of Disabilities and Special Needs
<b>DJJ</b>	= Department of Juvenile Justice
<b>DMH</b>	= Department of Mental Health
<b>DSS</b>	= Department of Social Services
<b>IFCCS</b>	= Intensive Foster Care and Clinical Services
<b>SCSDB</b>	= South Carolina School for the Deaf and the Blind

**OTHER CRITERIA/SPECIAL RESTRICTIONS**

1. Each provider shall be responsible for:
  - a) attempting to identify during the intake process whether an applicant is already receiving case management services from another Medicaid provider and
  - b) notifying any other involved Medicaid case management providers of an applicant's request for services.

2. Each provider must bill Medicaid according to Case Management Hierarchy Guidelines for each individual receiving case management services from another Medicaid provider.
3. Needed services should never be denied to an individual because another provider has been designated the Primary Case Manager.
4. Each provider shall timely notify other involved agencies or providers if an individual in an overlapping situation terminates their services.

### **EXCEPTIONS TO THE HIERARCHY/RESOLUTION PROCESS**

Each provider is encouraged to resolve any exceptions to the Case Management Hierarchy at the local level. When an exception exists, these guidelines must be followed:

1. If a Concurrent Care provider is predominantly meeting the treatment and service needs of the individual OR if the Primary Case Manager has failed to adequately coordinate care and services, the Concurrent Care provider may initiate contact with the Primary Case Manager at the local level to request a change in the Primary Case Manager. A meeting should be set up between the two agencies to discuss the feasibility of a change in the Primary Case Manager.
2. Contacts (telephone or face-to-face) between the Concurrent Care provider and the Primary Case Manager concerning a change in Primary Case Manager as well as the final determination of a Primary Case Manager must be documented in each provider's case management record. Although documentation of these activities is required, the activities are administrative and are not reimbursable by Medicaid.
3. If the state agency or main office administrators are unable to reach a determination of the most appropriate Primary Case Manager, the case should be referred to the Department of Health and Human Services for review.
4. The Department of Health and Human Services may make the determination of the most appropriate Primary Case Manager or may request that a team of other agency representatives make the determination.
5. The involved Medicaid providers will be notified within 45 days after the case is received by DHHS whether a change in the primary case manager is warranted.